

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5702

CERTIFICATE OF DEATH

05691

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent M		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FANNIE B. BAILEY			4. DATE OF DEATH Month Day Year May 13, 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1873	9. AGE (In years last birthday) yrs. 86	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel K. Fretz		14. MOTHER'S MAIDEN NAME Mary E. Bayer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Bramble, Address Millington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334 X central Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arterio-sclerosis DUE TO (c) Seriously					INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs 10 years yes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Hour a. 11. p. m. None 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) None		20g. (County) None		20h. (State) None	
21. I certify that I attended the deceased from Nov 1957 19__ to May 13 19__ that I last saw the deceased alive on May 13 19__ and that death occurred at 1130 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE H. H. Hamilton		M.D. Millington Md		DATE SIGNED 5/13/59	
PHYSICIAN'S NAME (Type) H. H. HAMILTON		MILLINGTON MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 16, 1959		22c. NAME OF CEMETERY OR CREMATORY Millington Cemetery	
22d. LOCATION (City, town, or county) Millington, Kent Co.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Edward S. Hollows		ADDRESS Millington Md		24a. REC'D BY REGISTRAR MAY 20 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5692

CERTIFICATE OF DEATH

Reg. Dist. No.

05692

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Cann		4. DATE OF DEATH Month May Day 12 , Year 1959	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1914
9. AGE (In years lost birthday) yrs. 44		10. IF UNDER 1 YEAR Months 4 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Cann		14. MOTHER'S MAIDEN NAME Katie Walker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-20-7679	
17. INFORMANT Levenia Maynor		18. ADDRESS (Street, city or town, state) Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO 460X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thrombophlebitis of leg (c) Varicocoeles		INTERVAL BETWEEN ONSET AND DEATH 1-2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Marked obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 12, 1959 , to May 12, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 11:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry Paul Ross		DATE SIGNED 203 N. Queen St	
PHYSICIAN'S NAME (Type) HARRY PAUL ROSS		Chestertown, Maryland	
22a. BURIAL, CREMATION, REBURY (Specify) Burial		22b. DATE THEREOF May 16, 1959	
22c. NAME OF CEMETERY OR CREMATORY Janex Cem.		22d. LOCATION (City, town, or county) (State) near Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

Form 10-1-55

1. Name of deceased: [REDACTED]

2. Sex: [REDACTED]

3. Date of birth: [REDACTED]

4. Place of birth: [REDACTED]

5. Usual residence: [REDACTED]

6. Date of death: [REDACTED]

7. Time of death: [REDACTED]

8. Cause of death: [REDACTED]

9. Immediate cause of death: [REDACTED]

10. Underlying cause of death: [REDACTED]

11. Manner of death: [REDACTED]

12. Physician: [REDACTED]

13. Signature of physician: [REDACTED]

14. Date of signature: [REDACTED]

15. Signature of registrar: [REDACTED]

16. Date of registration: [REDACTED]

17. Signature of informant: [REDACTED]

18. Date of information: [REDACTED]

19. Signature of informant: [REDACTED]

20. Date of information: [REDACTED]

21. Signature of informant: [REDACTED]

22. Date of information: [REDACTED]

23. Signature of informant: [REDACTED]

24. Date of information: [REDACTED]

25. Signature of informant: [REDACTED]

26. Date of information: [REDACTED]

27. Signature of informant: [REDACTED]

28. Date of information: [REDACTED]

29. Signature of informant: [REDACTED]

30. Date of information: [REDACTED]

31. Name of informant: [REDACTED]

32. Sex of informant: [REDACTED]

33. Date of birth of informant: [REDACTED]

34. Place of birth of informant: [REDACTED]

35. Usual residence of informant: [REDACTED]

36. Date of death of informant: [REDACTED]

37. Time of death of informant: [REDACTED]

38. Cause of death of informant: [REDACTED]

39. Immediate cause of death of informant: [REDACTED]

40. Underlying cause of death of informant: [REDACTED]

41. Manner of death of informant: [REDACTED]

42. Physician of informant: [REDACTED]

43. Signature of physician of informant: [REDACTED]

44. Date of signature of informant: [REDACTED]

45. Signature of registrar of informant: [REDACTED]

46. Date of registration of informant: [REDACTED]

47. Signature of informant of informant: [REDACTED]

48. Date of information of informant: [REDACTED]

49. Signature of informant of informant: [REDACTED]

50. Date of information of informant: [REDACTED]

51. Signature of informant of informant: [REDACTED]

52. Date of information of informant: [REDACTED]

53. Signature of informant of informant: [REDACTED]

54. Date of information of informant: [REDACTED]

55. Signature of informant of informant: [REDACTED]

56. Date of information of informant: [REDACTED]

57. Signature of informant of informant: [REDACTED]

58. Date of information of informant: [REDACTED]

59. Signature of informant of informant: [REDACTED]

60. Date of information of informant: [REDACTED]

5693

CERTIFICATE OF DEATH

Reg. Dist. No.

05693

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES'</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sudlersville</u> 17X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent and Queen Anne's Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Le Roy</u> Middle <u>Hodge</u> Last <u>COLEMAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 4, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W. Rudolphus Coleman</u>		14. MOTHER'S MAIDEN NAME <u>ANNA Nickerson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hosp. Records, Chestertown</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-13</u> , 19 <u>59</u> , to <u>5-16</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-16-59</u> , 19 <u>59</u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>A.C. Dick</u> M.D.		5-16-59	
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>		<u>Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>MAY 20</u>	<u>CRUMPTON</u>	<u>CRUMPTON MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Rane</u>		ADDRESS <u>Church Hill</u>	24a. REC'D BY REGISTRAR <u>MAY 21 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur & Thoma</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G243 5/28/59 cap

CERTIFICATE OF DEATH

05694

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Still Pond		c. LENGTH OF STAY IN 1b adult life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Davis Last Davis		4. DATE OF DEATH Month May Day 20 Year 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 12, 1865
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 9 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Don't Know		14. MOTHER'S MAIDEN NAME Don't Know	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Don't Know (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Kent Co. Welfare Board		Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Thrombosis 454X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Old age. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 15, 1959 to May 20, 1959 , that I last saw the deceased alive on May 20th, 1959 , and that death occurred at 4 p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. P. Atwell		M.D. Still Pond, Md. DATE SIGNED 5/21/59	
PHYSICIAN'S NAME (Type) L. P. Atwell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/59	22c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.	22d. LOCATION (City, town, or county) (State) Still Pond, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Enneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE MAY 25 '59		24b. REGISTRAR'S SIGNATURE Clara S. Friend	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5704

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FANNIE Middle A. Last DIXON		4. DATE OF DEATH Month May Day 23 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 24, 1867
9. AGE (In years last birthday) yrs. 92		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emory Camp		14. MOTHER'S MAIDEN NAME Susan A. Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Pearle Fogwell,		Address Galena, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2 days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1 , 19 59 , to May 23 , 19 59 , that I last saw the deceased alive on May 23 , 19 59 , and that death occurred at 9:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Ovenshain		ADDRESS (Street, city or town, state) Cecilton, Md. DATE SIGNED 25 May 59	
PHYSICIAN'S NAME (Type) WALLACE OVENSHAIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May, 27, 1959	22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery	22d. LOCATION (City, town, or county) (State) Galena, Kent Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Edward Sellers		24a. REC'D BY REGISTRAR DATE MAY 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

5705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05696

Reg. Dist. No.

FOR STATE
HEALTH DEPT1. PLACE OF DEATH
a. COUNTY

Kent

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Maryland

b. COUNTY

Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rock Hall

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rock Hall

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Piney Neck

d. STREET ADDRESS

Piney Neck

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒3. NAME OF
DECEASED
(Type or print)First Middle Last
Mary Elizabeth Gaines4. DATE
OF
DEATHMonth Day Year
May 16 1959

5. SEX

F

6. COLOR OR RACE

C

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

Oct. 10, 1911

9. AGE (In years
last birthday)

47 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

laborer

10b. KIND OF BUSINESS OR INDUSTRY

cannery

11. BIRTHPLACE (State or foreign country)

Kent Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac Hynson

14. MOTHER'S MAIDEN NAME

Mittie Black

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

212-30-8156

17. INFORMANT

Address
William Hynson Rock Hall, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Congestive heart failure

INTERVAL BETWEEN
ONSET AND DEATH
2 months

581.0 DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b) Anasarea

2 months

DUE TO Probable Hepatitis and Cirrhosis of

(c) Liver

1 or 2 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS
PRIMARY ☐ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Month, Day, Year
Hour o. m.
p. m.

19

20d. INJURY OCCURRED
While at work ☐ Not while
at work ☐20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐ACTUAL
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S
NAME (Type)

Robert W. Farr, M. D.

5/18/59

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

5/18/59

22c. NAME OF CEMETERY OR CREMATORY

Sharptown Cemetery

22d. LOCATION (City, town, or county)

Rock Hall, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Marvin V. Williams

ADDRESS

Chestertown, Md.

24a. REC'D BY REGISTRAR

DATE MAY 19 '59

24b. REGISTRAR'S SIGNATURE

Arthur S. Hume

5706 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Main St. + Haven Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma I</u> Middle <u>Hanna</u> Last <u>Hanna</u>				4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 19, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeping</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles W. Hanna</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Crawford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Mattie J. Davis</u>		Address <u>Rock Hall Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year _____ Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March, 1959</u> , to <u>May 13, 1959</u> , that I last saw the deceased alive on <u>May 13, 1959</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>E. Lester</u> M.D. <u>Rock Hall</u> PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am.</u>		22d. LOCATION (City, town, or county) <u>Rock Hall Maryland</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin V. Williams</u> ADDRESS <u>Chestertown Md</u>				24a. REC'D BY REGISTRAR <u>May 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED [Name]</p>		<p>2. SEX [Male/Female]</p>		<p>3. AGE [Age]</p>	
<p>4. DATE OF DEATH [Date]</p>		<p>5. TIME OF DEATH [Time]</p>		<p>6. PLACE OF DEATH [Place]</p>	
<p>7. CAUSE OF DEATH [Cause]</p>		<p>8. MANNER OF DEATH [Manner]</p>		<p>9. PLACE OF BIRTH [Place]</p>	
<p>10. OCCUPATION [Occupation]</p>		<p>11. EDUCATION [Education]</p>		<p>12. MARITAL STATUS [Status]</p>	
<p>13. PREVIOUS ILLNESS [Illness]</p>		<p>14. PREVIOUS SURGERY [Surgery]</p>		<p>15. PREVIOUS TRAUMA [Trauma]</p>	
<p>16. PREVIOUS DRUGS [Drugs]</p>		<p>17. PREVIOUS ALCOHOL [Alcohol]</p>		<p>18. PREVIOUS TOBACCO [Tobacco]</p>	
<p>19. PREVIOUS RADIATION [Radiation]</p>		<p>20. PREVIOUS CHEMOTHERAPY [Chemotherapy]</p>		<p>21. PREVIOUS TRANSFUSION [Transfusion]</p>	
<p>22. PREVIOUS ORGANS [Organs]</p>		<p>23. PREVIOUS TISSUES [Tissues]</p>		<p>24. PREVIOUS CELLS [Cells]</p>	
<p>25. PREVIOUS BLOOD [Blood]</p>		<p>26. PREVIOUS SPERM [Sperm]</p>		<p>27. PREVIOUS EGG [Egg]</p>	
<p>28. PREVIOUS OTHER [Other]</p>		<p>29. PREVIOUS UNKNOWN [Unknown]</p>		<p>30. PREVIOUS MISCELLANEOUS [Miscellaneous]</p>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05698

5699

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b less than 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Kent & Queen Anne Hosp.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia d. STREET ADDRESS 6911 Linmore Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Russell G Smith First Middle Last		4. DATE OF DEATH May 30 19 59 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1917 yrs. Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Mary Lawrence	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW 2		16. SOCIAL SECURITY NO. 353.1	
17. INFORMANT Personal papers found in car of deceased		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unknown, but possibly due to a combination of natural and accidental causes. Frequently a patient in VA hospital. Carried drug resembling Dilantin. Had had an old operation on left side, upper frontal area of head. Was drinking, dove into water, was pulled out, vomited at 6 PM. Seen by MD who said he had no idea of what was going on. Had visited hospital. Died en route at about 9:30 PM. Had been talking to wife at time of death. DUE TO (b) an old operation on left side, upper frontal area of head. DUE TO (c) head. Was drinking, dove into water, was pulled out, vomited at 6 PM. Seen by MD who said he had no idea of what was going on. Had visited hospital. Died en route at about 9:30 PM. Had been talking to wife at time of death.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. dove in water at Kennmore Park Md, May have had a seizure after entering water.		20b. DESCRIBE HOW INJURY OCCURRED (Enter as above in Part I, if possible) Waterfront near Kennedyville, Kent, Md.	
20c. TIME OF INJURY Month, Day, Year 5 a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Waterfront near Kennedyville, Kent, Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> ? Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED May 31, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/3/59	
22c. NAME OF CEMETERY OR CREMATORY Beverly Nat. Cem.		22d. LOCATION (City, town, or county) (State) Beverly New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		24a. REC'D BY REGISTRAR June 2 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5707 CERTIFICATE OF DEATH

Reg. Dist. No.

05699

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN 1b life	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD Edesville		d. STREET ADDRESS RFD Edesville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Natasha Middle Lynette Last Stewart		4. DATE OF DEATH Month May Day 29 , Year 1959	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1959
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 3	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cleveland Stewart		14. MOTHER'S MAIDEN NAME Mary Ann Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mary Ann Thomas Stewart		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature Infarction, 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/29 , 19 59 , to 5/29 , 19 59 , that I last saw the deceased alive on 5/29 , 19 59 , and that death occurred at 8:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Eugene Kester		ADDRESS (Street, city or town, state) Rock Hall, Md. DATE SIGNED 5/30/59	
PHYSICIAN'S NAME (Type) Eugene Kester			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 30, 1959	
22c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		22d. LOCATION (City, town, or county) (State) Rock Hall, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Walker 2012201XY2		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Fraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

2007

1-1-2007

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1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES E. SMITH		Male		White		10-15-1945		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Date of death		15. Place of death		16. Usual residence		17. Cause of death		18. Manner of death		19. Signature of physician		20. Signature of registrar	
Teacher		High School		Married		1-1-2007		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]	
21. Date of death		22. Place of death		23. Usual residence		24. Cause of death		25. Manner of death		26. Signature of physician		27. Signature of registrar		28. Signature of physician		29. Signature of registrar		30. Signature of physician	
1-1-2007		Baltimore, Md.		Baltimore, Md.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

1-1-2007

5708 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LILLIE Middle THOMAS Last THOMAS				4. DATE OF DEATH Month May Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1888	
9. AGE (In years last birthday) yrs. 70		10. AGE (In years last birthday) yrs. 70		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home			
13. FATHER'S NAME Elliot Brown				14. MOTHER'S MAIDEN NAME Lillie Ford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Waman Thomas,		Address Millington, Md. R.D.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (stroke). 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) Cerebral hemorrhage, hemiplegia INTERVAL BETWEEN ONSET AND DEATH 3 days 15-20 years 14 years						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 22, 1959 , to May 15, 1959 , that I last saw the deceased alive on May 12, 1959 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John Koralowski				ADDRESS (Street, city or town, state) MILLINGTON, MD			
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI				DATE SIGNED 5-16-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 18, 1959		22c. NAME OF CEMETERY OR CREMATORY Chesterville Cemetery		22d. LOCATION (City, town, or county) (State) Rural Millington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE MAY 19 1959		24b. REGISTRAR'S SIGNATURE Orthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be obtained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAVY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

[illegible]

4427-1

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5700 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent Freeman Hospital</u>				e. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elva</u> Middle <u>Elizabeth</u> Last <u>Wessel</u>				4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-17-12</u>	
9. AGE (In years last birthday) <u>46</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Alice Cranor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Hosp. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>post-operative</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-12</u> , 19 <u>59</u> , to <u>5-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>5-18</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>A.C. Tink</u> M.D.				PHYSICIAN'S NAME (Type) <u>A.C. Tink</u> <u>Chestertown, Md</u> <u>5-19-59</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 21, 1959</u>		<u>Chesapeake</u>		<u>Chestertown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Edwards</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAY 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a discrepancy, a problem is identified.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05702

5701

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b less than 1 day X Worton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Raymond Middle Alfred Last Wilson			4. DATE OF DEATH Month May Day 30 Year 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3 1931	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA			13. FATHER'S NAME James E. Wilson		
14. MOTHER'S MAIDEN NAME Hynson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1951-1953		
16. SOCIAL SECURITY NO. 215-26-5795			17. INFORMANT Magnolia Wilson Worton, Md. (Wife)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Natural (Probably coronary thrombosis) DUE TO Conditions, if any, which gave rise to immediate cause (b) Deceased, previously perfectly well awakened (c) from his sleep and complained of severe pain in his chest and back, which radiated to his arm. He took bicarbonate for presumed indigestion, and fell over unconscious after about 1/2 hour. Was dead on arrival at the hospital.					INTERVAL BETWEEN ONSET AND DEATH 1/2 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chest and back, which radiated to his arm. He took bicarbonate for presumed indigestion, and fell over unconscious after about 1/2 hour. Was dead on arrival at the hospital.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.			
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert W. Farr			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) ROBERT W. FARR			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6/3/59		
22c. NAME OF CEMETERY OR CREMATORY Butlertown Cem.			22d. LOCATION (City, town, or county) (State) Worton, Md. Kent Co.		
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Weller			24a. REC'D BY REGISTRAR DATE JUN 2 '59		
ADDRESS Chestertown, Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Comments

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05703

5709

1. PLACE OF DEATH o. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Galena				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Mary F. Wise				4. DATE OF DEATH Month Day Year May 21 19 59			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 26, 1891	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Caulk			14. MOTHER'S MAIDEN NAME Hester Vilo				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	17. INFORMANT James Wise, Address Golts, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute heart failure 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) regeneration of the myocardium. DUE TO (c) phlebotomic heart disease						INTERVAL BETWEEN ONSET AND DEATH 6 days 2 years? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 28, 19 59 to May 21, 19 59 , that I last saw the deceased alive on May 19, 19 59 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Geza Koralewski			ADDRESS (Street, city or town, state) Millington, Md.		DATE SIGNED 5-22-59		
PHYSICIAN'S NAME (Type) GEZA KORALEWSKI							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/25/59	22c. NAME OF CEMETERY OR CREMATORY Olivet Hill Cem.		22d. LOCATION (City, town, or county) (State) Rural Galena Md		
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Holloway			ADDRESS Millington Md.		24a. REC'D BY REGISTRAR DATE MAY 27 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

